

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032305

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4657

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1

28150

3

4 0

5 2

6

7 0

8 1

9443X

10

11

1276-0

13

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. DATE OF DEATH  
SEP 13 1963

a. COUNTY

JACKSON

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR  
TOWN KANSAS CITY

Length of stay in 1b  
28 days

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR  
INSTITUTION V A HOSPITAL

Inside Limits  
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE KANSAS b. COUNTY CRAWFORD

c. CITY  
OR  
TOWN PITTSBURG

Inside Limits  
Yes ☐ No ☐

d. STREET  
ADDRESS 120 1/2 FOURTH

Reside on Farm  
Yes ☐ No ☐

3. NAME OF DECEASED  
(Type or print)

First Middle Last  
THOMAS R KENT

4. DATE  
OF  
DEATH August 20, 1963

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☐ Never Married ☐  
Widowed ☒ Divorced ☐

8. DATE OF BIRTH  
8-5-88

9. AGE (last birthday)  
75

IF UNDER 1 YEAR IF UNDER 24 HR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY  
Salesman

11. BIRTHPLACE (City and state or country)  
Minden, Missouri

12. CITIZEN OF WHAT COUNTRY  
U.S.A.

13a. FATHER'S NAME

Hicy Kent

13b. MOTHER'S MAIDEN NAME

Mary White

14. NAME OF HUSBAND OR WIFE

Hallie Kent

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)

Yes

WWI

16. SOCIAL SECURITY NO.

17. INFORMANT W. O. Kent, brother

VA Hospital Official Records, K.C. Mo.

18. CAUSE OF DEATH (Enter only one cause per line  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pulmonary edema

INTERVAL BETWEEN  
ONSET AND DEATH

Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

DUE TO (b)

Left ventricular failure

DUE TO (c)

Hypertensive cardiovascular disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal  
disease condition given in PART I (a)

PART III. If deceased was female was  
there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY  
PERFORMED?  
YES ☒ NO ☐

20a. ACCIDENT - SUICIDE HOMICIDE  
☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF  
INJURY Hour Month, Day, Year  
a.m. p.m.

20d. INJURY OCCURRED  
WHILE AT WORK ☐  
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home,  
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. attended the deceased from July 23, 1963 to August 20, 1963  
Death occurred at 8:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)

S. H. CHOY M.D.

22b. ADDRESS

VA Hospital, Kansas City, Mo.

22c. DATE SIGNED

8-21-63

23a. BURIAL, CREMATION,  
REMOVAL (Specify)

Removal

23b. DATE

August 22, '63

23c. NAME OF CEMETERY OR CREMATORY

Highland Park

23d. LOCATION (City, town, or county)

Pittsburg, Kansas

24. FUNERAL DIRECTOR

Smith Funeral Home

ADDRESS

Pittsburg, Kansas

25. DATE RECD. BY LOCAL REG.

8-22-63

26. REGISTRAR'S SIGNATURE

Bessie Smith

CERTIFICATE

CAPITAL

RECEIVED

AMOUNT

2000 02

1000 02

RECEIVED

X

RECEIVED A 7

2000 02 02

1000 02

X

RECEIVED

1000 02

1000 02

X

RECEIVED

1000 02

1000 02

1000 02

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**STATEMENT BY LICENSED EMBALMER**

embalmer's statement

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Poland P. Funks*

Licensed Embalmer No. 3604

P. O. Address Indy, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.